Healing™ MAGAZINE

Providing practical, clinical information to families and children's professionals

2016 Vol. 21, No. 1

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About KidsPeace
KidsPeace is a private charity dedicated to serving the behavioral and mental health needs of children, preadolescents and teens. Founded in 1882, KidsPeace provides a unique psychiatric hospital, a comprehensive range of residential treatment programs, accredited educational services and a variety of foster care and community programs to give hope, help and healing to children, families and communities. Learn more at www.kidspeace.org.

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Are you interested in writing for *Healing Magazine*?

If you are a professional in the field of mental health, education or parenting, we welcome your submission. Healing articles should be about 1,200 words and consist of practical, clinical information about children's mental health that can be applied in the home, classroom, community and/or office setting.

Articles can be sent to healing@kidspeace.org.

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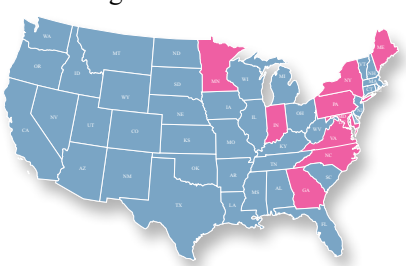

Dear Friend of KidsPeace,

Welcome to the 20th Anniversary edition of *Healing Magazine*! We're delighted to have you join us in celebrating our efforts to provide information and encouragement to those dedicated to helping our most precious resource – our kids – at their most vulnerable moments.

In this special issue, we're taking the opportunity of the anniversary to take both "a look back" and "a look forward." We are revisiting topics discussed in our first issue from 1996, including the advances in acute partial hospitalization care, art therapy in residential treatment and the development of play therapy theory. (On that last subject, we're pleased to share the thoughts of Dr. Heidi Kaduson of the Play Therapy Training Institute, who authored the **original** article in *Healing's* Issue #1 back in 1996!)

As for looking ahead, this issue also tackles challenges that are likely to have a significant impact on the field of mental and behavior health care for children in the future:

- Dr. Matthew Koval discusses the important issue of "polypharmacy" and the challenge it poses to accurate diagnosis and treatment of patients in crisis.
- Gender variance is in the news right now; we look at how such considerations may be reflected in residential treatment programs.
- And we discuss the promise of telepsychiatry, a great example of technology improving access to needed care in community-based programs.

Add articles on aging out of foster care, and a look back AND forward at our TeenCentral.Net website, and you get a issue that's worthy of *Healing's* 20th anniversary!

As always, we welcome your feedback on *Healing* and its articles, so please let us know what you think. You can also view this issue as well as back issues electronically at our new website HealingMagazine.org, and please visit kidspeace.org for more information about us and what we do.

In Issue #1, my predecessor John Peter first offered readers an invitation that has stood for two decades, and that I'm pleased to offer again:

Join us in conversation. Join us in cooperation to bring hope and healing to children, to give kids peace. And enjoy your visit through the pages of "Healing Magazine."

Will Isemann

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A.P.H.P. Then

In the Spring/Summer 1996 issue of Healing Magazine, KidsPeace announced the addition of an Acute Partial Hospitalization Program to its list of offered services. 20 years later, the program remains an integral part of the organization's continuum of care.

Healing Magazine Issue #1, 1996 – *"A therapeutic alternative to inpatient hospitalization"*

As states continue to decrease the usage of residential treatment facilities, the use of Acute Partial Hospitalization Programs (APHPs) has increased along with other community programs. Patients admitted to the program suffer from moderate to severe mental health issues that impair their ability to function within the home, school, and community. The main purpose of APHPs remains unchanged; to prevent out-of-home placement, reduce recurring crises and keep children in the least restrictive environment.

As was the case twenty years ago, APHPs are divided into two developmental age groups: children ages 6 to 12 and adolescents ages 13 to 18. Classrooms receive six hours a day of treatment, five days per week, with clients returning to their homes in the evenings and on weekends. Additionally, individualized treatment plans are designed for each client by an interdisciplinary team.

Over the years, the content of these treatment plans has been altered to meet regulatory needs that focus on data and strengths. For example, a treatment plan twenty years ago could have one generic goal, but today goals must be extremely individualized and strength based, with measurable interventions. Data collection now plays an important role in showing how well interventions are working and objectives are being met.

Another big change is where therapy can take place. In the early years, it wasn't uncommon for APHPs to take clients off grounds to movies or swimming as behavior modification rewards. For us at KidsPeace, the advent of managed care organizations (MCOs) in Pennsylvania fifteen years ago changed that practice. MCOs made it clear reimbursement of services would be limited to actual locations and addresses, and programs were not longer able to bill for any off-site activities, including transportation. Gone are the days when a classroom could go outside for an hour of flag football, followed by a movie at the local theater for clients who exhibited appropriate behaviors. Today, even recreational activities must have a clear treatment purpose and team-building component, reflect treatment goals and occur on the provider's property to be considered therapeutic and eligible for reimbursement.

"Filling the gap in the continuum of care"

At KidsPeace, continuum of care remains an organizational commitment to fill gaps in care and allow patients the opportunity to continue treatment in a structured setting, which greatly reduces the incidence of recurrence or another hospitalization.

Our APHP program has evolved, again mostly from regulatory requirements, with a focus on what the six-hour program day looks like. When unveiled in 1996, the APHP was described as a six-hour program with each child receiving four to five sessions of intensive therapy, as well as one hour of academic tutoring. Now, due again to changes in reimbursement policies, treatment days are more structured, with six unique therapeutic sessions that utilize a psycho-educational approach, without specific time set aside for tutoring.

The daily progress note has also undergone several revisions - going from a simple DAP (date/assessment/plan) note that covered the entire day to a note broken into six hourly segments, each requiring a connection to the master treatment plan.

and Now

By Chris Ferry

KidsPeace facilities in Fountian Hill and Temple, PA.

From 1996 to present day, Acute Partial Hospitalization Programs remain a fundamental level of care for children and adolescents suffering from moderate to severe mental health issues.

"Child and family friendly"

The intake process remains relatively unchanged, with a focus on obtaining accurate clinical information from an interdisciplinary team consisting of a psychiatrist, the family/caregiver, master's level clinician, nurse, and any outside agency. All services within community-based programs must be focused on supporting a client and family across the spectrum of home, school, and community, and every decision and recommendation is done with the hope that a child and their supports can function independently without the need for a more restrictive environment.

A typical intake session will last between one and two hours and include a biopsychosocial history and nursing assessment. As with many health organizations, the intake paperwork also includes numerous forms designed to inform the client and family of their rights and protected health information (PHI). In the past, one release was enough, but now rules dealing with specially protected health information and need-to-know considerations warrant additional and specific releases.

2016 operations

Initially started at the Broadway Campus in Fountain Hill, PA, KidsPeace's APHP services are now also available at the Berks campus in Temple, PA. Combined, these two programs serve over 500 clients per year.

When admitted into an APHP a client will receive the following:

- Psychiatric evaluation and medication management from an on-site child psychiatrist
- Treatment plan that is strength based, measurable, and developed by a team
- Group, individual and family therapy from a master's level therapist
- Six hours of structured therapy daily
- A strong family and aftercare component to help clients in reaching their goals.

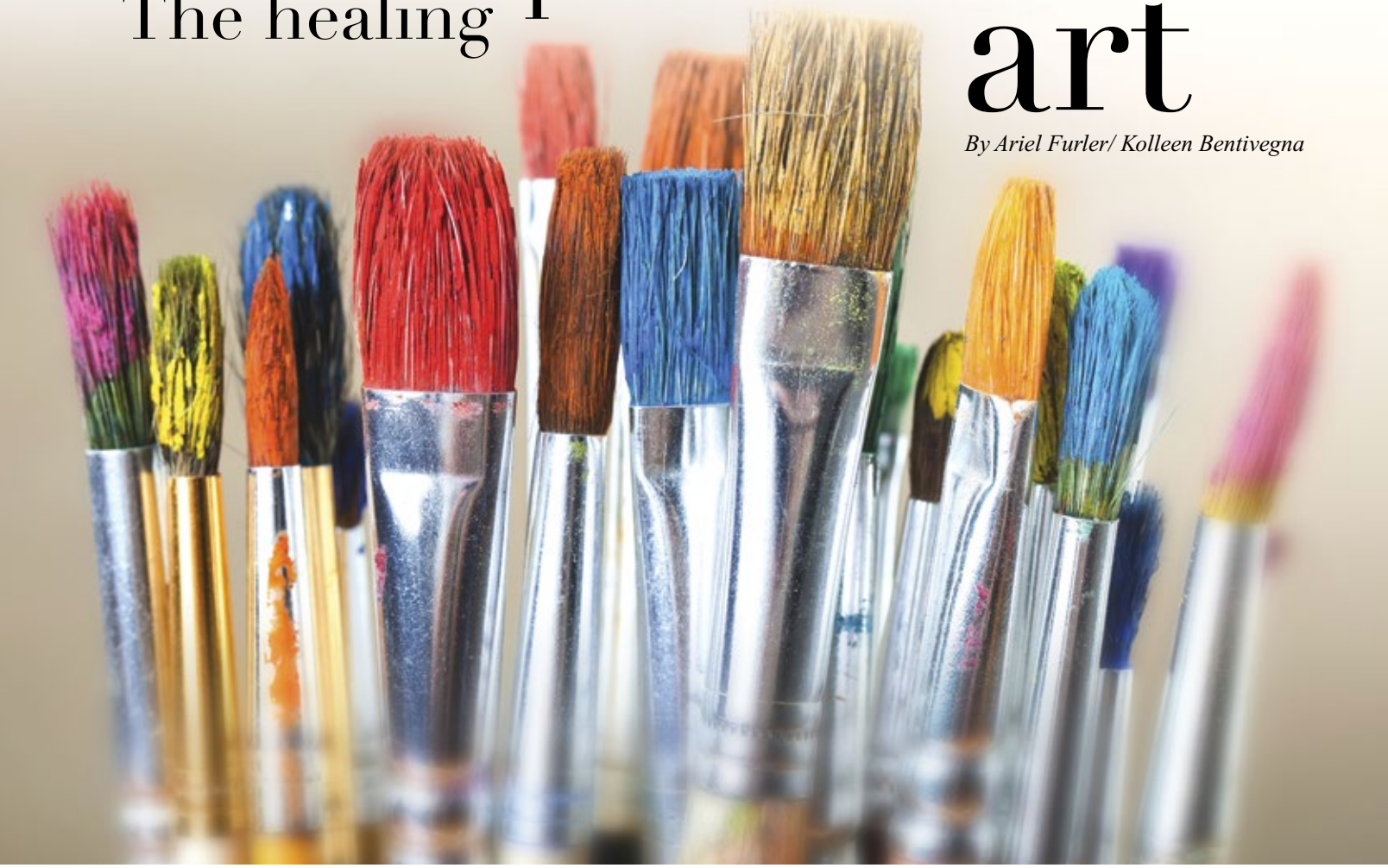
Over the years, the acuity of an APHP client has increased for several reasons, from a push to limit residential treatment to general changes in society. Today, as MCOs dictate what is considered best practice, our programs get referrals for children that would have been more appropriately served in a residential setting in the past, because the consensus now is that treating children and adolescents in the community yields the best prognosis.

From 1996 to present day, Acute Partial Hospitalization Programs remain a fundamental level of care for children and adolescents suffering from moderate to severe mental health issues. Although several revisions have been made to the treatment plan and restrictions to where therapy can occur, the framework of the program remains relatively unchanged. APHPs have and will continue to have a place in mental health services as a way to prevent out-of-home placement, reduce crisis, and keep children in the least restrictive environment.

Chris Ferry, MA, NCSP is a school psychologist who currently serves as KidsPeace Executive Director of Pennsylvania Community Programs. In this role he oversees four outpatient, three partial hospitalization and four autism-specific programs – which together provide services to more than 5,000 individuals each year. He has been on the KidsPeace staff since 1998.

The healing power of art

By Ariel Furler/ Kolleen Bentivegna



A standard feature in the early issues of Healing Magazine was "KidsArt", highlighting a piece of artwork created by one of our clients. Two decades later, art therapy is an important component to residential treatment programming at KidsPeace.

Over the past twenty years many things have changed at KidsPeace, including the population we serve. In the 1990s and early 2000s, KidsPeace served many clients with conduct disorder and behavioral issues. But in recent years, we've seen a shift towards more clients diagnosed with mental health disorders, traumatized individuals, and those diagnosed with autism. As our clientele has changed, so have the services offered to them. Among the services that have benefitted these new clients at KidsPeace is art therapy.

Art therapy can be carried out through many different methods, but the goal is always to benefit the mental and emotional well-being of the client. The practice itself is centered on using the creative process to express emotions and conflicts within our clients. Using art as a tool of expression can be cathartic and healing in and of itself, but reflecting on the process and content of produced art with a trained art therapist can make the experience even richer. Everyone has the ability to succeed in art therapy, even if they have never been deemed artistic or demonstrated any interest in art. The results are not meant to be hung in a museum, or even on a refrigerator; the art is meant as a communication tool between the client and therapist.

We see how our clients struggle with communication on a regular basis, and for that reason art can be a powerful way for children to communicate non-verbally or indirectly through their art work. The client may even communicate ideas to themselves that they were previously unaware of due to unconscious thought. The following case illustrates this concept:

John has a problem controlling his anger when he is told he is not allowed to do something. He explodes; others around him react, and his anger gets out of control as he begins to become violent. Depression follows and his thoughts take him to a dangerous place of suicidal ideation along with thoughts of hurting others. He is asked to make art representing his anger. In response, John starts to make a mask out of plaster gauze. He takes care to smooth the surface, reinforces the mask with several layers for strength, and starts thinking

We see how our clients struggle with communication on a regular basis, and for that reason art can be a powerful way for children to communicate non-verbally or indirectly through their art work.

of how his anger would be portrayed. "How do you make horns?" he asks, "I want to make a devil." The art therapist guides him on how to make devil horns, then he affixes them to his mask. The art therapist begins asking him questions about what it feels like to be so mad and why he becomes so frustrated when he is told he is not allowed to do something. These questions are met with "I dunno," and silence. Is the devil mad? "Yes." What happens when the devil is mad? "He destroys things." Is there a way we can talk to the devil to try to keep him out of the house when he gets mad? "Maybe." From this point a dialogue is created and John is able to discuss his anger by projecting his thoughts and emotions onto the devil mask. This makes John feel safer to express himself when something is too difficult to speak about directly.

In addition to identification and expression of anger and other emotions, art therapy can focus on emotional regulation, increasing social skills, and practicing impulse control. Our clients can benefit from all art therapy interventions, regardless of their history or diagnoses, due to the personal nature and inherent capability of each individual to communicate visually.

The process of art therapy often requires educating our clients in the techniques that they can utilize to improve their ability to cope with stressors in and out of sessions. Many identify creative acts such as coloring, drawing, and journaling among their "likes;" these are areas that can be reinforced to promote a sense of well-being and relaxation. A unique facet of creative therapies is that they typically involve the whole person, physically and emotionally. Keeping the mind and body focused on purposeful action can center attention and decrease impulsivity. In exploratory art therapy sessions, clients have the opportunity to discover various techniques that they may find interesting and will respond to in an effort to relax. Repetitive actions such as patterning mandalas, creating Zentangles, and crocheting or other fiber arts are common favorites. After participating and completing these tasks, the calming experience of the process is often met with feelings of accomplishment and pride of having simply created.

The creation of aesthetic beauty is never the sole intention in art therapy, but when clients do find beauty or satisfaction in their creation and its message, a self-esteem boost and confidence in personal capability is a common result. Beaming children beckoning an adult with "Look what I did!" is a result of growing autonomy while seeking reassurance that yes, they are *able*. It may seem simple, but the act of creating and exercising imagination is a natural process for youth which can yield impressive results in the development of positive identity and esteem.

The experience of practicing methods and utilizing developmentally appropriate materials is integral to building self-esteem through mastery in art therapy. Our clientele in residential treatment demonstrate significant need to construct belief in personal strengths. Through art, "I can't do anything right" may be changed to, "I *can* find pictures that I like, I *can* make a collage about myself with these, and I *can* say what I like about myself." Reinforcing an ability to succeed in these processes makes visual communication a modality to be emphasized in treating youth with histories that have made them feel powerless. Taking control through art therapy is often an enjoyable way to foster empowerment through being able to feel something, do something, and say something all through one piece of art.

Looking to the future, we are finding more ways to engage our clients through a wide variety of mediums that can be engaging for diverse interests and needs. We are incorporating technology into our services; photography and iPads stimulate enthusiasm for select art therapy sessions because we understand that adaptive use of modern machines is an important way for our clients to learn and communicate. To counterbalance the abundance of technology that our clients experience, we incorporate nature-based art therapy services that take kids into the elements for wilderness-based art therapy, and into a "zen-garden" for art therapy-based mindfulness exercises. The availability of these unique facilities in addition to traditional methods such as drawing, painting, sculpting, weaving, and building during art therapy groups ensures that we will pique the interest of our youth of today and tomorrow.

A key factor in successful mental and behavioral health treatment is personal engagement by the client. By facilitating such engagement, art therapy serves as a powerful modality that has effective results through the interaction of fun and work.

(Continued on page 12)

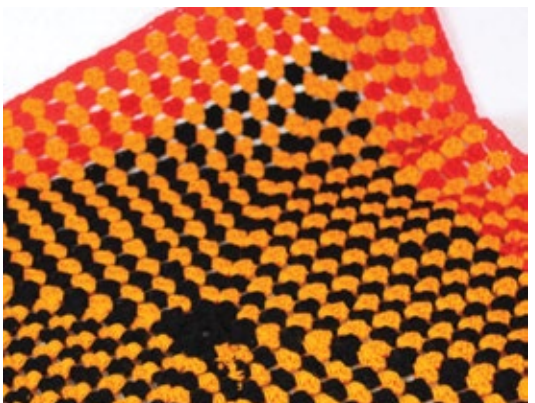
Client art showcase on next page.

(Continued from page 11: The power of art)

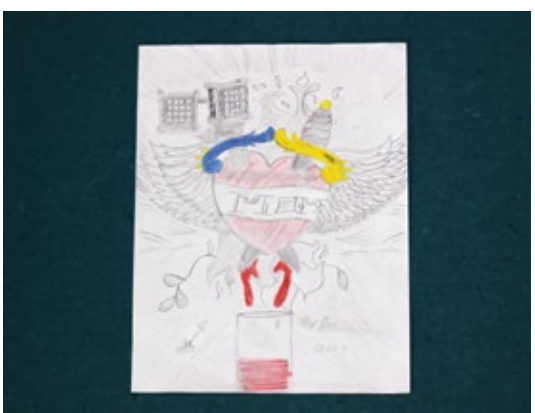
Title: Life by: Alexis
Materials: acrylic paint on canvas
Depiction of emotional expression of different genders

Title: Unique by: Diamonique
Materials: tissue paper, rice paper, and glue
Represents light, hope, and faith

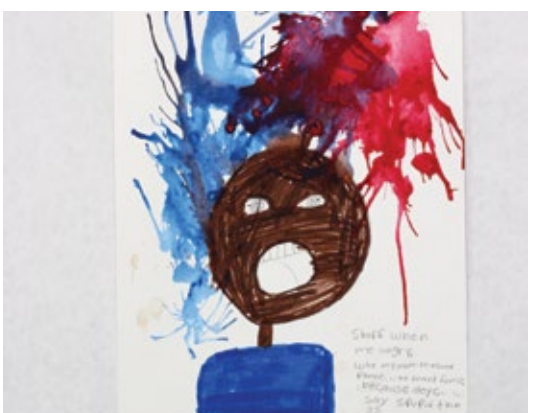
Title: Eagle of Freedom by: Jahnai L.
Materials: mixed media
This mask represents what I have overcome and the freedom I have being at KidsPeace.



Title: Flyers Blanket by: Brianna
Materials: yarn
Crocheted expression of enthusiasm for the NHL team



Title: Indestructible by: Ethan V.
Materials: pencil on paper
Rising up from the pain I have experienced in my life. Nothing can bring me down.



Title: Anger by: Jesus T.
Materials: paint on paper
How I feel when I get angry and find it difficult to communicate.

Ariel Furler is an art therapist at the Pioneer Center at KidsPeace's Orchard Hills Campus in Pennsylvania, and also works as an independent artist in the Lehigh Valley. She earned a Master of Science degree in art therapy and counseling from Eastern Virginia Medical School, and has experience as an international educator.

Kolleen Bentivegna is a registered art therapist, and obtained her master's degree in art therapy from the School of the Art Institute of Chicago. She currently works with youth in the Patriot Center on the KidsPeace Orchard Hills Campus. Kolleen has her own art therapy private practice, Well-Rooted Wellness, working with members of the Lehigh Valley community.

"Playing is a very natural way for children to deal with everyday, as well as emotional, problems. As clinicians, we have become aware of the value of play in helping children 'talk' to us. Play, after all, is the language of the child."

Heidi Kaduson, Healing Magazine Issue # 1, 1996.

HEALING THROUGH PLAY

BY Heidi G. Kaduson, Ph.D., RPT-S

Over the last 20 years, the view of play therapy as a treatment modality intended only for children has expanded to include adolescents, young adults and geriatric populations. Play is considered so important to optimal child development that it has been recognized by the United Nations High Commission for Human Rights as a right of every child, and even the American Academy of Pediatrics has a comprehensive article about how important play is to a child[1]. Other articles note that the decline of play seems to be correlated with the rise in children's mental disorders.

In my new book, *Play Therapy Across the Lifespan: Infants, children, adolescents and adults* (published by Guilford Publications), play therapy treatment is used on people of all ages through prescriptive play therapy[2]. Prescriptive play therapy is a therapeutic approach that incorporates a variety of theories and techniques to customize the play intervention to meet the specific and diverse needs of individual clients. The use of prescriptive treatments challenges the play therapist to examine the strengths and weaknesses of specific theoretical orientations for treating various disorders.

There are six tenets to the prescriptive play therapy approach:

1 *Individualized Treatment.* The aim of prescriptive play therapy is to tailor the play intervention to meet the individual needs of the client. What works for one person may not work for another, so the prescriptive therapist seeks to tailor the intervention not only to the disorder but also to the personal characteristics and situation of the client[3].

2 *Differential Therapeutics.* Throughout the history of play therapy, no one theoretical school (e.g., Rogerian, Adlerian, or Jungian) has proven strong enough to produce optimal change across the many different and complex psychological disorders that have been identified[4]. The prescriptive approach to play therapy[5] is based on the core premise of differential therapeutics, which holds that some play interventions are more effective than others for certain disorders and a client who does poorly with one type of play therapy may do well with another[6,7]. Rather than forcing clients to adapt to one therapeutic modality, prescriptive therapists vary the remedies they provide to meet the different treatment needs of individual clients.

3 *Trans-theoretical Approach.* In order to tailor the treatment intervention to the individual needs of the client, one must be trans-theoretical or *eclectic.* Eclectic therapists use the criteria of empirical evidence, clinical experience, and the desires of the client to select from different theories and techniques the best therapeutic change agents for a particular client[8]. These thera-

pists reject strict adherence to any one school and instead select what is most valid or useful from a wide therapeutic spectrum. Prescriptive therapists believe that the more modalities you have in your repertoire, coupled with knowledge about how to differentially apply them, the more effective you will be across the multitude of presenting problems one encounters in clinical practice[9]. According to Norcross, "synthetic eclecticism" involves combining various theories into one coordinated treatment intervention. This is different than just picking out an intervention to use from a menu, which is an atheoretical treatment approach. Norcross warns against such practice, and finds it haphazard and ineffective at best, and may in fact be harmful to some clients[8].

4 *Integrative Psychotherapy.* This type of psychotherapy is used to describe any multimodal approach, which combines two or more theories. Prescriptive play therapists are not confined to single-school theories, and they often combine different theories and techniques to strengthen an intervention and broaden the scope of their practice. An integrated, multi-component intervention reflects the complex and multidimensional nature of most psychological disorders, which arises from the fact that they are caused by an interaction of biological, psychological, and social factors. Since there is a high co-morbidity among many psychological disorders, the interventions must be done with an integrated treatment approach. The integrative psychotherapy practiced by most prescriptive play therapists is termed assimilative integrative[10]. This means that they began their career with one primary orientation, and then gradually incorporated or assimilated practices from other schools.

5 *Prescriptive Matching.* Prescriptive play therapists seek to match the most effective play therapy intervention to a specific disorder[8]. In a treatment plan, the prescriptive play therapist selects a therapeutic change agent that is designed to reduce or eliminate the cause of the problem. Thus, by treating the symptoms and the underlying cause, the problem will be less likely to reoccur in the future.

6 *Comprehensive Assessment.* This might be costly and time consuming, but a comprehensive clinical assessment provides the therapist with an in-depth understanding of the child, the family and the origins of the child's presenting difficulties. It also enables the therapist to customize the treatment to the individual needs and problems of the client. Additionally, this assessment helps parents understand the origins of the child's presenting problem. This can be accomplished by doing a comprehensive intake with the parents first, and developing case formulation from that session. The therapist can get the nature of the problem, history of previous therapy, parents' treatment preferences/expectations, child and family's readiness and motivation for change, and empirically based guidelines for treating the presenting problem. The family history, client strengths, trauma history, medical history and developmental history can also be done within that session. All of the foregoing results in preparing a case formulation prior to the initiation of therapy. With that completed, the development of an individualized treatment plan – or the prescription – can be done which will specify the treatment goals and strategies. Additional assessments can be done by giving parents behavior rating scales.

Whether they are 2 or 82, play therapy can be an effective intervention. For the young, the research is clear because play is the language of the child. For the adolescent and adults, play therapy is beneficial because it can help alleviate the emotional difficulties that have been spoken about over and over again in talk therapy, but without psychological relief.

It is important that the play therapist is playful and silly when needed as well. Playfulness is not a universal trait, and there can be some difficulties if the therapist does not join as a playful participant when doing techniques with children, adolescents, young adults, and geriatric populations. *A Playfulness Scale for Adults*[11] lists out the five factors that are included in being playful: is fun loving, has a sense of humor, enjoys silliness, is informal, and is whimsical.

Lastly, prescriptive play therapists use a pragmatic approach: Basically, if it works, use it. The best therapeutic intervention is one that gets the job done with an individual case in the most cost-effective manner.

Heidi Gerard Kaduson, Ph.D., RPT-S is Director of The Play Therapy Training Institute, Inc., as well as a Licensed Clinical Psychologist in New Jersey and New York, along with being a Registered Play Therapist Supervisor. She has trained and supervised thousands of people across the world. Dr. Kaduson has written and edited numerous books and articles, including The Playing Cure, 101 Favorite Play Therapy Techniques, 101 More Favorite Play Therapy Techniques, 101 Favorite Play Therapy Techniques: Volume III, Short-Term Play Therapy (First, Second and Third Editions), Contemporary lay Therapy, and Play Therapy Across the Lifespan: infants, children, adolescents, and adults. She has also created a DVD CEU on Play Therapy for children with ADHD, and another DVD CEU on Play Therapy for Children with Pervasive Developmental Disorders. Dr. Kaduson maintains a private practice in Monroe Township, NJ

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Whether they are 2 or 82, play therapy can be an effective intervention. For the young, the research is clear because play is the language of the child.

Therapeutic Power	Beneficial Outcome
Overcoming resistance	Working alliance
Competence	Self-esteem
Catharsis	Emotional release
Communication	Understanding
Creative thinking	Problem solving
Abreaction	Adjustment to trauma
Role play	Practice new behaviors
Metaphoric teaching	Insight
Attachment formation	Attachment
Positive emotion	Ego Boost
Mastery	Growth and development

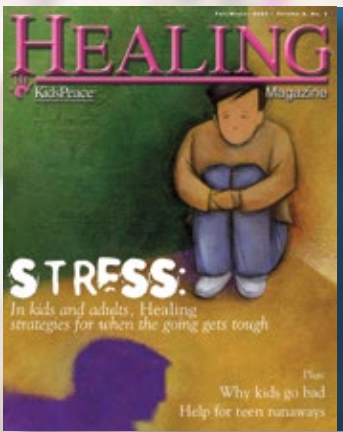
Play therapists use the therapeutic powers of play to help children manage their worlds better and reduce psychological distress. Listed in the chart to the left are some examples of the beneficial outcomes of these therapeutic powers.

At first, Allen slumped along the wall and took little interest in the tape images made by the Tape Art team. After the introduction by Mike and Erica, participants were offered tape and encouraged to find their place… A half hour later, Allen rose to his feet and began to slowly and carefully lay tape on the wooden door surfaces. At last there appeared a six-foot-high image of a head, screaming painfully…. Allen's therapist approached and stood supportively next to him. Allen looked up at her and said, "That's how I feel."

"Sticking with Therapy" – Issue #4, 1997

Splashes echo from the rafters along with laughter as young swimmers burn off the tensions and frustrations of the day… Quiet descends as children rest upon mats in the pool; the tranquility is reflected in their faces. Heavily panting, a hard-working child breaks into a huge grin as she realizes her accomplishment: She was able to swim more laps today than at her last session.

"Swimmers, Take Your Marks: Aquatic Therapy's A Splashing Success" – Issue #11, 2001



To prepare the other students for the return of their grieving classmates, they were given clear, honest information about what had happened on September 11. Student Assistance Specialists discussed appropriate words of sympathy and support that class members could offer their friends, such as, "I'm sorry about your dad," and "I'm glad you're back in school." Students were encouraged to avoid asking too many questions about their friends' losses but to listen well if their friends wanted to talk.

"I'm Sorry About Your Dad: Providing a School Based Grief Group" – Issue #15, 2003

I think everyone has robbed Peter to pay Paul at some point, but, in this situation … just remember that this same little boy or girl has already been robbed repeatedly to help pick up the slack of the State budget. How can we, with a clear conscience, say that it is OK to continue to ask a child who has been beaten or faced traumatic abuse … to continue to be responsible for balancing the budget? These kids have done more than their share. For the sake of those who cannot cry out about how bad these cuts hurt, let the blade pass them by this time around.

"KidsPeace Foster Parent Speaks up Against Cost Shifts"
– Issue #27, 2010

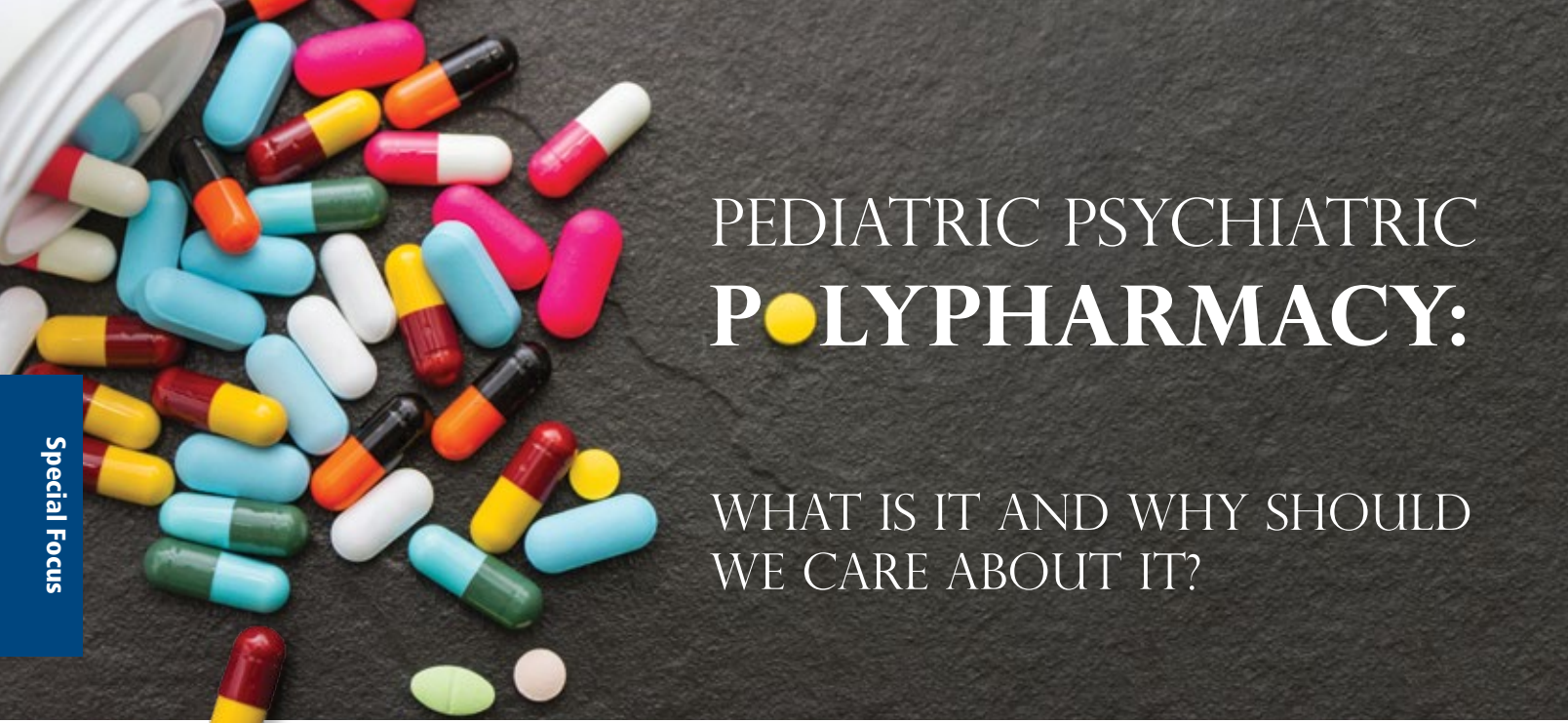
I met "Josie" at a workshop for military families. Josie's toddler daughter was a happy child during the day and seemed well adjusted to her deployed father's absence. But at night she refused to sleep in her own bed. Every night during the year her father was deployed, the little girl screamed herself to sleep on the floor outside her parents' bedroom. Everything changed when her father returned. The first night, she went to her own room unprompted, climbed into her own bed and settled in with a huge sign saying, "Daddy's home."

"Taking Care of Military-Connected Kids" - Issue #36, 2015

CELEBRATING 20 YEARS Healing MAGAZINE 1996-2016

D COUNTING

A LOOK FORWARD



Special Focus

PEDIATRIC PSYCHIATRIC POLYPHARMACY:

WHAT IS IT AND WHY SHOULD WE CARE ABOUT IT?

By Matthew S. Koval, M.D.

Pediatric psychiatric polypharmacy is the process of treating children and adolescents with more than two novel psychiatric medications for one or more mental health disorders. It has become a surprisingly common practice in the psychiatric treatment of youth despite little evidence that combining psychiatric drugs improves overall treatment efficacy. This is even more troubling when combined with the well-known fact that more complex drug regimens are associated with a greater risk of drug-drug interactions, side effects, and cost.

Unfortunately, the science of child and adolescent psychiatry has not caught up with common practice, giving prescribers very little guidance when making their treatment decisions. For example, many commonly prescribed drugs used to treat youth with emotional and behavioral problems are considered "off label" medications because they have not been approved by the Food and Drug Administration to treat their particular condition, or they have only been approved in adults and have not been sufficiently tested in children. In addition, when it comes to prescribing more than one medication, there are only a handful of studies that compare monotherapy with co-therapy (two medications) and no known studies looking at drug combinations of three or more agents.

In the last 15 years, however, polypharmacy rates have been on the rise; it is now estimated that one in five kids in outpatient samples who are treated for emotional or behavioral problems are treated with more than one psychiatric medication – and the rates are higher for those with chronic mental illness or those who suffer from more than one psychiatric illness (co-morbidities). It has been described that the number of out-of-home placements (hospitals, foster homes, group homes, etc.) that a young person has experienced is directly related to the likelihood that the youth will be treated with multiple simultaneous psychiatric medications. In fact, by the time young patients reach the level of residential treatment, about half are on three or more psychiatric medications.

Hopefully, most providers would subscribe to the idea that for any illness, a patient should be on the least amount of medication to do the job. A higher dose of medicine or adding a second or third medicine that does not result in noticeable improvement only increases the likelihood of drug interactions and side effects, and should be considered irrational polypharmacy and therefore should be avoided. However, treating a patient with multiple medications because they have co-morbid conditions that require different medications (like attention deficit/hyperactivity disorder (ADHD), with mood or anxiety disorders) could be considered rational use of polypharmacy. Furthermore, treating one "treatment resistant" condition like bipolar disorder with two or more medications (usually with different mechanisms of action) could also be justifiable, particularly if the combination is well tolerated by the patient.

In 2011 KidsPeace began to take a very close look at polypharmacy among those children we treat in our residential treatment facilities in Pennsylvania. With the help of a nationally recognized psychopharmacology consultant, we created a standard operating procedure aimed at safely reducing polypharmacy whenever possible in the residential population, reflecting the need for polypharmacy in appropriate cases.

Polypharmacy for KidsPeace's residential treatment programs was defined by any of three parameters:

- A youth being on more than three psychiatric medications
- A youth being on more than one psychiatric medication within the same class (e.g. antidepressant, mood stabilizer, stimulant, antipsychotic, etc.)
- A youth being on a dose of any agent higher than the maximum recommended dose as determined by the KidsPeace Pharmacy & Therapeutics Committee.

All clients in KidsPeace residential treatment were tracked and monitored. If any defined form of polypharmacy was initiated or continued, prescribers were required to justify why the particular medication regimen was deemed necessary. These cases also required approval from the KidsPeace medical director and specific polypharmacy consent from a parent or guardian as well as consent from any youth aged 14 or older.

Prior to the July 2011 roll out of the KidsPeace residential polypharmacy standard operating procedure, 35-40% of clients in Pennsylvania residential were on more than three psychiatric medications. In addition, around 30% of clients were taking two or more psychiatric medications in the same class. In the span of six months, the number of clients taking more than three psychiatric medications fell to around 12% and the number taking two or more medications from the same psychiatric class fell to around 10%. By the end of the first year, the overall polypharmacy rate (of any defined type) for clients in KidsPeace residential was less than 10% and the number has not been above 15% since – exemplifying the resolve that KidsPeace has demonstrated for this important initiative.

There may have been concerns that reduction in polypharmacy would lead to increased behavior problems or prolonged lengths of stay. Fortunately, this simply wasn't true. Overall, it appears that KidsPeace residential clients were able to show the necessary improvements required to earn discharge on less medication, emphasizing the importance of non-medication psychosocial interventions such as individual therapy, family therapy, group therapy, and milieu therapy. In fact, between 2012 and 2016, only 3.7% of clients were discharged from KidsPeace Pennsylvania residential programs on more than three psychiatric medications or more than two medications of the same class. A recent scientific study has indicated that in the supportive milieu of residential treatment, thoughtful reassessment of diagnoses and prescriptions can result in the use of less psychiatric medication while also resulting in a reduction in assaultive incidents and the use of physical restraints. Another study showed that reduction of polypharmacy resulted in improved short and long term outcomes while saving money on discontinued medications (in this study a yearly savings of over $250,000 in less than 200 patients).

At KidsPeace, when a patient is referred for treatment in our residential programs, our providers begin their initial assessment by carefully reviewing records from previous providers and performing a skillful interview of the client and family members or guardians. Patients are often referred to KidsPeace already on polypharmacy, and many times the review of records and clinical interviews indicate that some medications are simply not working and can be safely tapered and discontinued. While this re-assessment is occurring, residential clients are enrolled in a comprehensive therapeutic program that utilizes a mixture of individual, group, and family based therapies to recognize and increase control over negative moods, broaden self-esteem, bolster coping skills, improve decision making, and help the young person maintain the safety of themselves and those around them. When medications are prescribed, they are matched with a diagnosis or specific symptoms, utilizing evidence-based data to support their use. If a patient's symptoms are not responding appropriately to the current treatment regimen and a new medication is to be added, we look at whether it is possible that one of the other medications can be taken away.

As our clients improve, we continually assess the ongoing need for their medication regimen; progress in treatment sometimes means that certain medications can be safely reduced or discontinued and the best time to accomplish this is while the individual is part of the structured and secure setting of residential treatment. We recognize that some of the patients we serve are struggling with multiple psychiatric diagnoses and will require at times aggressive medication management, but we approach all patients with the hope that clinical improvement may result in the reduction of unnecessary polypharmacy.

Following the success of our efforts in residential, we have expanded our polypharmacy reduction efforts to KidsPeace Hospital. The acute hospital patient presents unique challenges in terms of managing polypharmacy; hospital patients are with us for a much shorter period of time, which tends to make meaningful medication reduction efforts more difficult, but no less important. Discharge from KidsPeace Hospital on more than one antipsychotic medication now requires KidsPeace Hospital medical director approval.

Polypharmacy reduction has become a goal in our community programs as well. KidsPeace has expanded our partial hospitalization programs to provide alternatives to pharmacologic-based treatments, and we now offer evidence-based therapies such as Trauma Focused Cognitive Behavior Therapy (TF-CBT), and Parent-Child Interaction Therapy (PCIT); both of which can provide sources of immense healing for patients and their families without relying solely on medications.

We are quite proud of the polypharmacy reduction we have been a part of at KidsPeace, but we want to make it clear that reduction of polypharmacy is not our only goal. Helping youth, their families, and communities heal has been, and will always be, central to the KidsPeace

(Continued on page 24)

Gender variance:
Implications for Mental Health Treatment

By Thespina Arcure and Jonna Finocchio

Over the past few years, visibility for the transgender community has risen to an all-time high. It is no surprise that mental health professionals are witnessing what appears to be an influx of transgender and gender-variant individuals in care. In reality, gender variance has always existed; however, the recent increase in visibility has created a forum for transgender people to have a more open dialogue with service providers. But many mental health providers and their agencies say they feel unprepared and ill-equipped to provide ethical and culturally competent treatment in response to these emerging issues.

The field of mental health is dynamic and ever-evolving, and the presence of unique and unfamiliar issues is commonplace in our profession. To achieve clinical competency, we are called to educate ourselves about gender identity issues in the same way that we are called to educate ourselves in other matters. While clinical competency is a cornerstone in this endeavor, a knowledgeable provider cannot affect change in a stagnant system. The intention of this article is to provide guidelines for the professional to increase competency and identify the infrastructure needed to create a safe and affirming treatment environment.

Transgender individuals face a variety of challenges throughout their lifespan. From a very early age, children are socialized to understand gender as a culturally constructed binary of male-female, prescribing what is considered to be socially acceptable behaviors, preferences, and expressions. In doing so, this gender binary creates outliers. In an effort to avoid isolation and fulfill the need for belonging, children may feel compelled to participate in gender-conforming behaviors that are at odds with their true sense of self. This creates a paradox in which both conformity and non-conformity produce distress in the individual. As transgender individuals explore their gender identity, they may also face ridicule, disapproval, or even complete rejection from those around them.

Historically, mental health providers have been critiqued as pathologizing gender non-conformity and conceptualizing treatment as an effort to make the client more comfortable in their assigned sex. This ideology is most evident in earlier versions of the Diagnostic and Statistical Manual, which classified gender incongruence as a mental illness. The recent publication of the DSM 5 and the new diagnosis of Gender Dysphoria have created a paradigm shift, in which we no longer view gender variance through the lens of disease. Instead, the goal of treatment is to alleviate the discomfort and distress associated with the incongruence between one's gender identity and assigned sex at birth.

As helping professionals we must become culturally competent in our work with this population and set the stage for acceptance. There are many practical ways to embody this effort. We must first consider the role of our personal values and how they may impact the treatment we provide. At times, the values of the helping professional may conflict with the values or behaviors of the client. These conflicts must be recognized and addressed to prevent potential influence on the therapeutic experience. Furthermore, as professionals we must take every opportunity presented to challenge the misinformation, lack of acceptance, and outright hatred which may occur around us, and embrace our role as advocates for change.

The most critical aspect of treatment in working with gender-variant individuals is the establishment of a strong and healthy therapeutic relationship which is immersed in unconditional positive regard. Unconditional positive regard is crucial in relationship-building, and

it must be accompanied by established practical measures which allow the individual to feel safe and respected:

- **Never assume.** All gender-variant individuals are unique. We must be careful not to generalize the transgender experience. It is vitally important to ask our clients to self-identify so that we can adopt their language and refer to them correctly.

- **Always use the client's "preferred" name and pronouns.** Misgendering our clients, whether intentionally or unintentionally, has a lasting and significant negative impact and can set the tone for treatment.

- **Respect privacy and confidentiality.** Information about a client's gender identity is personal. We should discuss with the client how, when, and with whom information is to be shared.

- **Be knowledgeable.** Helping professionals should have at least a cursory knowledge of the different social and medical transitions available to a transgender person. Additionally, professionals should be mindful that not all transgender individuals will wish to transition.

- **Be informed.** Be prepared with information on support services and other resources available to the client in their area. At times, you may need to invest time and effort into finding reputable and safe resources for your transgender clients.

- **Be realistic.** The transgender population will inevitably encounter resistance and hardships in society. Helping professionals should be prepared to have dialogue with clients about potential safety concerns, and promote resiliency through the development of coping skills and supports.

Apart from the role of the professional in offering competent care, we must also address the therapeutic setting. Even in environments which strive for inclusivity and equality, there are often subtle forms of aggression, or microaggressions, which shape the experience of the transgender individual in that environment. The creation of safe spaces is a powerful tool, but it is important to note that safe spaces cannot thrive where hate speech and microaggressions are permissible. The implementation of a standard operating procedure creates a framework to establish a safe space and ensure that quality of care is afforded to transgender individuals.

Some recommended components of this standard operating procedure are:

- **Establish placement guidelines if necessary.** When admitting clients to inpatient or residential settings, admissions should work to obtain information regarding the client's placement preferences and gender identity. These preferences should be communicated to the agency leadership making placement decisions. All efforts should be made to accommodate the client in the environment of their choosing.

- **Facilitate preparation of staff (and peers as necessary).** There should be clear expectations for staff to respect the dignity of each client. However, additional accommodations may be needed for the safety of transgender clients. In addition, it may be necessary to prepare existing clients for the arrival of a transgender individual. This approach should be carefully considered by the treatment team and include input from the client and their supports.

- **Respect gender expression.** Clients have the right to be treated fairly and should be permitted to outwardly express themselves within the established dress code and safety regulations of the program.

- **Address bullying and harassment immediately.** Staff should take a firm stance against bullying and harassment and address issues as they arise, ensuring the physical and psychological safety of the client at all times.

- **Avoid microaggressions.** Microaggressions are subtle negative comments and/or behaviors towards marginalized groups that often exacerbate stereotypes. Examples include: "I have a cousin like you," or "You are so pretty for a trans girl."

- **Remove gender rigidity.** This includes the use of gender neutral signage, gender-affirming language, and the elimination of gender stereotypes. If possible, provide clients with the use of gender-neutral or single-occupancy bathrooms and/or changing rooms.

We must endeavor to improve both as individuals in practice and as members of a larger system, in order to provide optimal treatment to the transgender community within an environment in which we embrace individuals on their own terms. This environment will allow the individual to authenticate themselves; to be resilient and grounded in their role while existing as an outlying member of the normative culture.

As helping professionals, the culture of inclusion and acceptance begins with us.

Thespina Arcure, M.S., is a therapist and the Senior Clinical Program and Staff Development Specialist for KidsPeace. She is also a certified LGBTQIAA trainer.

Jonna Finocchio is a licensed clinical social worker and clinician within the KidsPeace Diagnostic Program. She is also an LGBTQ consultant for KidsPeace Community Programs, as well as a speaker and advocate for improving the quality of healthcare for transgender people.

The most critical aspect of treatment in working with gender-variant individuals is the establishment of a strong and healthy therapeutic relationship which is immersed in unconditional positive regard.

Telepsychiatry

Helping improve access to care

If an individual is struggling with mental health issues and wants to be seen by a professional in the field, they may have a long wait ahead of them. Accessing needed psychiatric care in a community setting can involve very long wait times; those seeking a first-time outpatient visit consistently face wait times of anywhere from a couple of months to a full year.

KidsPeace's outpatient clinics have tried to address this persistent gap in psychiatric care availability by offering a free walk-in assessment to anyone in need. During this session a therapist can identify the type of psychiatric care the client needs, and those in acute or immediate need can be referred to inpatient hospital care or a day treatment program. But those in the range of mild to moderate need again will face long wait times for an evaluation – largely due to a shortage of psychiatrists.

Lack of doctors equals gaps in care

The shortage of psychiatrists is not a new phenomenon. Except in certain urban areas, psychiatrists now are spread thinly throughout the country, and enticing a psychiatrist to a non-urban area can be a challenge. Furthermore, medical schools are not graduating many new psychiatrists. According to the National Institute for Mental Health, only 4% of U.S. medical school seniors applied for a psychiatry training position in 2011. This amounted to about 700 doctors in a year in which over 1,000 such positions were available across the country.

Consider New York, a state of 20 million people, but only 3,400 licensed psychiatrists. By comparison, the New York Occupational Board reports that the state has three times as many trained chefs, and five times as many dentists.

So, if you want to get a nice meal in New York, you can do this easily and without much of a wait. If you break your tooth on a beef rib while eating at one of those restaurants, you may be able to see a dentist even faster. But if you are emotionally traumatized by the experience, and require a psychiatric evaluation, you will have to wait to get care.

Worldwide, the shortage is even more acute. There are about 3,500 psychiatrists in India, a nation of 1.2 billion people. That is about one psychiatrist for every 343,000 people. To put it in American terms, you would need to fill seven Yankee Stadiums (holding 50,000 people each) to find one psychiatrist in India – a country where an estimated 76% of individuals with serious mental health conditions do not receive treatment.

Addressing the need through technology

Necessity being the mother of invention, this need for access to psychiatrists is inspiring creative solutions – including the idea of **telepsychiatry**, or using videoconferencing to allow a doctor to conduct evaluations without being physically present. It's an idea that seems to be gaining traction in underserved areas.

In India, telepsychiatry has provided a vital link to medical care for people who would otherwise be untreated. The Schizophrenia Research Program (also known as SCARF) is an Indian nonprofit that provides community outreach into 200 villages in the area surrounding the city of Chennai in the state of Tamil Nadu, India. The program sends a bus equipped with telepsychiatry capability and an onboard pharmacy into the area and treats whoever needs help and can access the service, free of charge. Countless lives have been touched by this service, allowing suffering people and their families to have access to needed treatment.

In the U.S., providers like KidsPeace have worked to gain approval for telepsychiatry, and in 2015 we received approval to begin to offer the service at four outpatient sites in Pennsylvania. With two major insurance companies having contracted to cover telepsychiatry, we are establishing the practice across five counties in the Keystone State.

How telepsychiatry works

To get an idea of how the service works at KidsPeace, we turn to an individual who recently received the service at our Tobyhanna, PA clinic – a patient we'll call "James" (not his real name):

- A KidsPeace associate called James to see if he would be interested in coming in for a psychiatric evaluation using telepsychiatry. James was initially hesitant, but he ultimately agreed to come in once the associate explained that taking advantage of this service would cut his wait time from two months down to one week. When he arrived for the appointment, James was greeted and given a Frequently Asked Questions sheet on telepsychiatry, and he signed a consent form to participate.
- The associate took James to a private office, where the HIPPA-compliant online service VSee was already prepared and running. The associate sat with James while he talked with our doctor via VSee, so he was able to answer any questions and advocate as needed. The technology worked well and there were no interruptions.
- At the end of the appointment the doctor called a prescription into James' pharmacy, which he picked up later that day.
- After the appointment, James completed a survey in which he reported that the service allowed him to have an appointment sooner than expected, the appointment was uninterrupted, and the process was clearly explained to him. He said that the overall experience was positive and he would do it again.

Challenges ahead

Telepsychiatry offers a promising new direction in the field, but it also comes with some challenges. One such difficulty involves technology. As anyone who has tried Facetime or Google Hangouts can attest, there are times when video conferencing does become glitchy or fail. VSee, the service used by KidsPeace, is web-based and there are occasional delays. However, in general it has proven reliable, and when there are problems our associates have been able to work through them.

Another challenge relates to costs. Cost-related study of the service has produced various results. Some believe that the upfront technology and staffing costs associated with telepsychiatry make it cost-prohibitive. This depends of course on factors like whether the service is reimbursable and at what rate of reimbursement. In Pennsylvania, one insurance company has established higher reimbursement rates for telepsychiatry, allowing more flexibility in its utilization. Regardless of cost considerations, the increased access to care for clients using the technology makes it valuable, even if it remains a break-even service.

Finally, some note concerns related to privacy. Confidentiality is an ethical obligation, and fears that a web-based service might become public, be intercepted, or corrupted are to be taken seriously. It is important to note that the technology we use is certified as HIPPA compliant, so the site itself is internally secure. If the site runs via a hard-wired or private Wi-Fi connection, there is increased security as well. There may be some concerns related to privacy if the site runs over a mobile phone network, but these types of connections are not utilized at this time.

Telepsychiatry is a promising application of technology in the field. It offers the potential to dramatically reduce wait times and improve access for individuals seeking care. While there are some concerns, these are proving minor and the benefits far outweigh the problems.

Jason Savenelli, LPC, is the Director of KidsPeace's Pennsylvania Community Programs. A graduate of Lehigh University, he is a clinician with nearly 20 years of experience working with children and families. He has expertise in cognitive behavioral therapy (specifically REBT, rational emotive behavior therapy) as well as treatment of children and teens affected by trauma.

Resources:

(http://www.nimh.nih.gov/about/director/2011/psychiatry-where-are-we-going.shtml)

http://www.wpanet.org/detail.php?section_id=21&content_id=338; http://cswr.columbia.edu/wp-content/uploads/2015/04/Reaching-the-Unreachable.pdf

http://timesofindia.indiatimes.com/city/chennai/Shortage-of-psychiatrists-hits-treatment/articleshow/29085662.cms

Telepsychiatry is a promising application of technology in the field. It offers the potential to dramatically reduce wait times and improve access for individuals seeking care.

Continued from page 19; Pediatric Psychiatric Polypharmacy:

mission. Appropriate use of psychiatric medication is an essential part of that healing process, but whenever polypharmacy is present, it must be rational and justifiable.

Matthew S. Koval, M.D., is Vice President of Medical Affairs at KidsPeace. He received his bachelor's and M.D. degrees from West Virginia University, and is board-certified in Child and Adolescent Psychiatry. Prior to KidsPeace, Dr. Koval was an associate professor and attending psychiatrist at the Medical University of South Carolina in Charleston, SC, where he also served as Director of Youth Inpatient Services and Assistant Director of Child and Adolescent Psychiatry Training. He has authored a number of presentations and articles on clinical topics in the psychiatric field.

ADVICE FOR PARENTS:

Psychiatric medications can be life-saving treatments that some patients may require for many, many years. Patients, parents and guardians should NEVER take it upon themselves to reduce or discontinue psychiatric medications for themselves or their loved ones. If there is concern about medications, you should have an open discussion with your provider:

- Ask the provider to go over the entire list of psychiatric medications and ask them to explain what each medication is treating.
- Ask about the classes of medications (antidepressant, mood stabilizer, antipsychotic, stimulant, etc.) and have the prescriber provide an explanation if two or more medications in the same class are recommended.
- Be prepared to describe which medications are working well, which are not working, and which have side effects that are unacceptable.
- Ask the provider if there are alternatives where a single medication can be used to treat more than one symptom or diagnosis (for example, certain antidepressants are helpful for both depression and anxiety disorders).
- Ask the provider about evidence-based non-medication therapies to treat troublesome symptoms or behaviors. There are excellent cognitive/behavioral treatments, family therapies, and parental techniques that have been shown to be extremely effective for nearly all kids with emotional and behavioral problems. It is important to understand that some of the best outcomes in child and adolescent psychiatry come about when talk therapy, parent training, and behavioral modification are coupled with appropriate medication therapy. Families often ask about what they can do to help their affected loved one; being willing to commit to ongoing therapy is one of the most powerful things families can do together to promote healing and well-being.
- Tell the provider that there is a concern about polypharmacy and directly ask the provider if there are any medications that can be safely reduced or discontinued.

All patients have the right to ask these questions, and should feel empowered to form a partnership with their psychiatric providers to reach their mutually agreed upon goals. Both parties (clients, families and providers) should approach the situation with open minds, a willingness to discuss issues, and a desire to learn from one another.

– M.K.

By Julius Licata, Ph.D.

Director of Website Reflects on Its History and Future

Sometimes, as I sit in my office, I think back to a little over 17 years ago when we were getting ready to launch this new and innovative website we called TeenCentral.Net. At that time, of course, most websites were pretty new. But this one had the chance to affect the lives of teens that needed help. We were very excited, and frankly a little nervous, over taking this new approach.

Well, here we are all those years later, and TeenCentral.Net has helped hundreds of thousands of teens all over the world. It also spawned a new site (ParentCentral.Net) to assist parents through their difficulties, and it's given many college students and volunteers the opportunity to offer counseling to teens visiting the site. In my opinion, we have much to be proud of.

Since we launched TeenCentral.net on September 8, 1998, teens have used the site to write about whatever is going on in their lives. These are called their "stories," and over its lifespan TeenCentral.Net can boast of having received more than 250,000 stories from teens all over the U.S. and internationally. It also has received just as many responses to stories. Teens continue to come to TeenCentral.Net seeking support, encouragement and help; they find a place of acceptance where they know they belong and are appreciated for who they are.

Over the years we have helped teens cope with so many issues – the Columbine tragedy, the attacks on the World Trade Center and the Pentagon, various horrible school shootings, divorces within so many families, deaths of loved ones and just about any other issue that can affect the lives of our teens. We have seen this site, created to be a place where teens can come to get answers and not judgment, grow beyond national boundaries and embrace teens throughout the world. They come to TeenCentral.Net because

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When AGE is More than Just a Number

By Sarah Harteis

It's a staggering statistic – every year, up to 25,000 foster children age out of the U.S. foster care system, often with little knowledge or experience of the basics of living on their own, like how to cook a simple meal or pay a bill. When that happens, research indicates the odds are stacked pretty high against them:

- Only about 46 percent earn a high school diploma.
- Within 18 months, 40 to 50 percent will end up homeless.
- Within two years, 25 percent will be incarcerated.

These kinds of statistics indicate a nationwide problem – one that KidsPeace and other organizations are trying to solve.

An "aging out" story

Rasheeda Sloan was adopted at birth into what she thought would be her forever family. Unfortunately, when she was 16 years old, she was removed from the comfort of her home and placed into the world of foster care to live with relatives, due to issues of unsafe housing.

Before entering foster care, Rasheeda had been homeschooled all her life; suddenly she was forced to become familiar with the public school system, a huge challenge for her that led to her failing the first semester of high school. When asked how her relatives responded to this, she said "They talked down to me like it was my fault, like I was dumb or something. Nothing I did ever seemed to be good enough."

She began supervised independent living in her own apartment when she was 19 and continued through her 21st birthday. "It was great," she recalls. "It gave me peace of mind to be out living on my own." But when Rasheeda turned 21 she was immediately discharged from foster care and had to leave her supervised apartment.

During her time in foster care she was taught some life skills, such as cooking, sewing, and cleaning, but there were other areas, such as financial concerns, that she had yet to figure out. She wanted to continue living on her own, but knew that wasn't a possibility. "I could've kept my apartment if I had a job," she says, "but I was a student and I had no money."

When asked what could have made her feel more prepared for her discharge, she noted a need for more programs designed to help kids after discharge – saying that there are good resources out there to help while in care, but after she left care all the support was abruptly cut off and she was left on her own.

Now 23, Rasheeda is living with relatives in Philadelphia, PA, and working full time to help adults who struggle with mental disabilities. She has big plans for her future that involve furthering her education and moving out and living on her own. "Even though I've had my ups and downs, I consider myself to be a survivor. I never went through anything physical, but I did go through a lot emotionally. My experience wasn't too bad, but it could have been better. I am thankful that it wasn't worse."

KEYS to success for the aging out

Rasheeda's story of struggle in the transition of aging out is certainly not unique among foster children. One program that strives to make that journey easier is the KidsPeace Empowering Youth to Succeed (KEYS) program, provided through KidsPeace's Maryland offices. The purpose of KEYS is to provide training on life skills for youth aging out of foster care to have a successful transition into adulthood.

"Few young adults leave home at 18 ready to care for themselves, so they rely on their adult support system to provide them with guidance, emotional support, housing and financial assistance," says volunteer coordinator Gina Seyfried. "But a young person in foster care often misses out on these supports. The KEYS program is here to offer tangible, hands-on activities to unlock their future success."

The KEYS program seeks to prepare youth to effectively implement learned skills in four important areas:

- **Life skills education groups** creatively teach important life skills through a 20-week program that addresses six main areas of development - Daily Living, Self-Care, Relationships & Communication, Housing & Money Management, Work & Study Life, and Career/Education Planning.

- **A job readiness program** is designed to provide youth with the opportunity to develop professional skills, explore career options, and gain experience that will help them sustain long term employment. Youth are provided one-on-one coaching, group training, career assessments, and leadership development.

- Another component to KEYS is **individual transition planning services**, in which youth in the program create a long-term education plan and receive assistance with securing employment, housing and health insurance before they turn 21.

- KEYS also provides access to a **Youth Advisory Board** to further teach independence through the encouragement of leadership skills, team building and problem solving.

Meanwhile, in Williamsport, Pennsylvania, KidsPeace offers Independent Living groups for support of older youth in Northumberland, Columbia, and Lycoming counties. A KidsPeace professional starts by assessing where the youth's deficiencies lie, and from there plans a curriculum based on the results. Ten sessions are conducted that help participants learn the skills they'll need to thrive in life.

A need for an emotional connection

The abrupt nature of "aging out" can make it one of the most devastating events in a young person's life. Often, when the time comes, a child may return home from school to find out they can't stay with their foster parents any longer, due to a lack of funding. Suddenly they find themselves all alone, with no support system in place and nowhere to go.

Debra Schilling Wolfe, M.Ed., is the executive director of the Field Center, an organization that aims to prepare the nation's future leaders. Wolfe says this lack of emotional connection—the sense of being cared about—may be one of the hardest aspects to foster youths to handle.

"Imagine if you will that your birthday came and went and nobody even wished you a happy birthday," she says. "That's what many of these kids experience. The system provides them with physical and emotional support but only until they're 18, or in some states 21, and then they wash their hands of them. You can't pay somebody to care about you."

The KEYS program, for one, tries to provide a measure of this emotional support. "For every youth who ages out of care with KidsPeace we have a 'Launch Party' to recognize this important transition and milestone 21st Birthday," explains Jocelyn Kennedy, KEYS coordinator. "Each youth is given a transition basket filled with household needs. Staff and treatment team members are invited to celebrate their proven resiliency and the beginning of the next stage in life."

The saying goes that age is just a number, but for thousands of kids each year, it represents much more than that. It represents the start of a new life for them, and for some a life they are not prepared to take on. Through programs like KEYS and independent living support, KidsPeace and other organizations are doing their best to find solutions for these kids, to help them feel ready and eager to transition into adulthood.

Sarah Harteis has been the Family Resource Specialist for KidsPeace FCCP in Duncansville, PA, for four years. She graduated from Shippensburg University in 2009 with a B.A. in communication/ journalism and a minor in psychology.

Seattle University's Fostering Scholars Program

KidsPeace and many agencies around the nation are attempting to teach essential life skills to older youth moving through the foster care system, as a crucial part of being able to live successfully on your own. One program takes it to another level, stressing the importance of furthering one's education beyond high school.

The Fostering Scholars program was established in 2006 at Seattle University in order to promote educational success for current and former foster youth. The program is designed to identify students whose achievements and goals mirror the University's mission and to allow these exceptional students to fully focus on their goals by providing financial, academic, and personal support towards the completion of an undergraduate degree.

In June 2015, 29 students were able to graduate from Seattle University thanks to the assistance they received through Fostering Scholars. The program has become a national model as one of the few programs of its kind at a private, independent university. According to Seattle University, program alumni are successfully pursuing careers and post-graduate degrees in a wide range of fields, including accounting, law, nursing, software development and social work.

"Because of the Fostering Scholars program, I am privileged to attend a wonderful university. I have the program advisors' and counselors' support. I have challenging classes that enable my skills and knowledge to expand every day." -Scholar, Class of 2013.

For more information on the Fostering Scholars Program, visit their website at www.seattleu.edu/fosteringscholars. – S.H.

(Continued from page 25; TeenCentral.Net)

they know they will get honest support from people who care, from an organization dedicated to helping others get beyond the difficulties they face now to move on with their lives and embrace the future full of hope.

Just as our numbers and reach have grown and changed, so has the age of our teens. When we started back in 1998, the site drew inquiries mostly from 15 to 18 year olds, with some coming from pre-teens and college students. Today, we find ourselves embracing 11-year-olds, and at times even younger children, who are looking for answers to the problems they face at home, in school, among their friends and peers and life in general.

While the age of visitors may have gone down, and the emphasis of stories may change, there are constants. The topics of stress, dating and relationships, friendship, sex and school seem to be a continuing focus. Teens are also very concerned about losing someone to death, teen pregnancy and teen violence. At the same time, topics like gay and lesbian issues, suicide and dealing with bullies have grown in importance more recently, reflecting what is going on in the world around us. Read just a few of the stories on the site, and you'll see teens are most definitely affected by current events; it takes its toll on their lives and the way they view life in general.

We live in a time of uncertainty and the changes are not always positive. Teens are more apprehensive about their future, fearing at times to be in public places and even worrying about attending school. It is very urgent for communities to be ever vigilant in learning how to protect and assure teens of their safety. TeenCentral.Net can keep watch on the pulse of our teens' lives, helping our communities become more aware of what is going on in the lives and minds of our youth.

One way is to listen to teens because they are talking and they are sharing – and they want to be heard! TeenCentral.Net not only listens but it is available 24/7 to answer their concerns and to intervene whenever necessary. This is one of the most innovative and constructive uses of the Internet – taking this medium one step further, not only to listen, but to advocate and teach, to answer and reassure.

The goal of TeenCentral.Net is not to become a private therapist, but to help guide the teen through some basic crisis intervention and counseling techniques – techniques that the teen can use to deal more effectively and maturely with future problems and difficulties. Teens tell us that it is very cathartic for them to write their feelings, and knowing there will be an answer from a trained counselor within 24 hours is an added benefit.

In short, TeenCentral.Net provides help and hope so that teens can move forward to a future filled with opportunities and not fall into fear and despair.

As I write this piece, TeenCentral.Net is undergoing a transformation. We have rebuilt the site on new and more effective software which will allow it to grow into the future, and we have redesigned it to make it more interactive and appealing to teens everywhere.

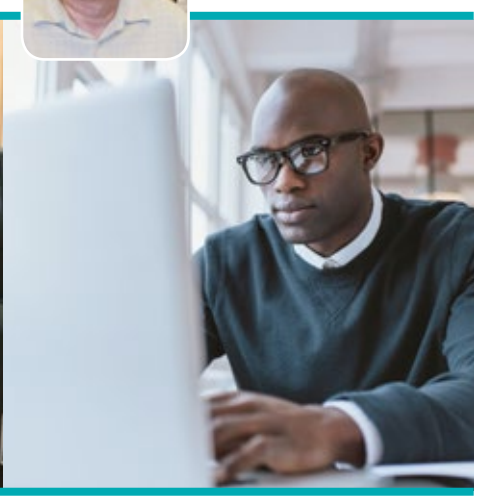
ParentCentral.Net™

TeenCentral.Net will keep its trademark anonymity, allowing teens to feel safe, secure and protected and thus able to bring any issue or problem without fear of being identified. This has worked for all these years and will continue to be the foundation upon which this site was built and continues to flourish.

From the success of TeenCentral.Net was born ParentCentral.Net. Parents often need someone they can trust, they also need advice on how to parent in a particular situation. They desperately seek to understand their children and this can be very difficult. ParentCentral.Net helps parents to get through difficult times without judgment and ridicule. They are gently guided through situations and problems. This approach works to help parents better understand their children and, with TeenCentral.Net supporting the teen, the result can be very positive.

These two sites provide the best in intervention and prevention at a time when they are most in need. So, whether you are a teen, parent, teacher, therapist or anyone seeking some support and/or help, simply go to www.teencentral.net or www.parentcentral.net and log on. From there, with the help of trained counselors and therapists, you will be guided to, as we have said for 17 years and counting, "work it out."

Julius Licata, Ph.D., is the founder and Director of TeenCentral.Net and ParentCentral.Net.



The Evolution of Quality Improvement in Behavioral Health Care

Before we can look at the future of quality improvement in behavioral healthcare, we have to look to the past to understand problems that have hindered quality improvement. For most of the history of medicine, behavioral healthcare as a discipline has been ignored, largely due to the public stigma around behavioral health and an even greater misunderstanding of the factors at work in mental illness. (The origin of the term "lunatic" is a good example of this long-held misunderstanding; it was derived from the Latin word for moon because it was thought that the cycle of the moon had an effect on a person's mental state.)

Quality improvement in healthcare as we recognize it today began with the establishment of the federal Medicare and Medicaid programs in 1965. As participants in those programs, providers had to meet a number of requirements – the most significant being the creation of the utilization review process as a safeguard against unnecessary and inappropriate medical treatment. Unfortunately, this requirement had the unintended consequence of creating a hyper-focus on documentation. Accurate and detailed documentation is both positive and necessary in making sure patients receive appropriate treatment; however, when quality improvement systems and regulatory systems are designed solely with content of documentation in mind, rather than the outcome of the individual patient, it is negative. The hyper-vigilance on documentation will be an issue that hinders quality improvement in behavioral healthcare for the next fifty years.

A second major constraint in quality improvement is the understanding about what is actually meant by quality. During the 1960s and into the 1980s a number of federal and state healthcare-related laws were passed with quality components to them. At the same time, the three largest accrediting agencies - the Joint Commission, Det Norske Veritas Healthcare, Inc., and the Healthcare Facilities Accreditation Program - also incorporated quality improvement components to their accreditation processes. But amid all the efforts to improve the services being provided, there was no single clear operational definition of what quality meant or how to improve it in the healthcare context, and this gap led to a number of false starts, incomplete projects and disillusionment among providers, who grew more resistant to try to improve or even to evaluate what currently was being done.

With no clear definition of quality in a healthcare context, and with accrediting bodies, state regulators and managed care organizations focused primarily on documentation, providers responded by creating quality assurances (QA) departments – a fixture in manufacturing industries since the 1920s. However, quality assurance in a manufacturing operation is designed to remove defective parts from the assembly line by the use of audits and sampling before they were sold to a customer - not on preventing the creation of a defective part (or delivery of a substandard service) in the first place.

During the 1980s and 1990s, QA departments in behavioral healthcare providers attempted to use Statistical Process Control (SPC) and Total Quality Management (TQM) tools. Both methods of continuous improvement failed to reach their true potential in those operations for two reasons – the lack of highly skilled individuals needed to administer QA efforts correctly, and the continuing hyper-vigilance on documentation rather than on patient care and outcomes.

As a result, during the 2000s a number of quality assurance departments changed their name to Quality Improvement (QI) departments, as a way to note a commitment to actually improving quality. The Plan-Do-Check-Act (PDCA) circle and Plan-Do-Study-Act (PDSA) circle were added to the QI toolbox, along with Correction Action Plans, later called Quality Improvement Plans. But again the issues of hyper-focus on documentation and

unclear meaning of quality in a behavioral health context resulted in these tools from the manufacturing sector, intended to improve services for the patient, being corrupted.

What was lost from the transition from the manufacturing sector to the behavioral healthcare field was the "how" and "why" of the Corrective Action Plan process. Instead of a thorough review dedicated to finding the true root cause of a defect in the process, and a clear unbiased evaluation of the impact on the patient's treatment and quality of life, more often than not in behavioral health settings you get a quick "looks good" plan focused on documentation.

Here's an example: during an audit of a patient's record the outside auditor finds that one note documenting a group session with the patient was missing a required field. The normal course of action of the outside auditor is to issue some type of infraction and request a correction action plan be done to prevent the error in the future. The provider's normal response is a Correction Action Plan listing what steps they will or have done, most likely some type of training. On the surface everything looks good: the outside auditor found an error and requested it corrected, and the provider responded with a plan on how to correct it using training. But the larger question is, did reviewing the document notes of treatment, or training a mental health professional for the second time to write a better note, actually **improve the providing of services to the patient?**

2010's federal Affordable Care Act required the development of a core set of health quality and performance measures to reduce cost and improve services. A number of groups began abandoning the old standards and applying the new health care metrics from the Centers for Medicare & Medicaid Services (CMS) to behavioral healthcare. In a short amount of time they realized that behavioral healthcare metrics and goals are different than those in medical healthcare. The underlining complexity and chronic nature of mental health conditions do not lend themselves to the same simple outcome measures as medical conditions. Metrics for behavioral healthcare need to be more segmented so that data can be compared among groups with similar factors which would impact the metric. For example, instead of comparing a patient's length of stay with a provider against the length of stay of the total population, the length of stay should be compared against the length of stay of other patients who were in the same factor segments for age, gender, education, location, and mental health diagnoses.

Fortunately, quality improvement is now evolving in ways that actually improve the system for both the patient and the provider, while maintaining quality and cost standards. This is largely done by first questioning if each metric and standard is truly helping the patient, and then asking how we can improve to surpass the metric and standard. Behavioral health providers have started to use continuous improvement methods like Lean and Lean Six Sigma (LSS). These approaches each feature their own methods, tools, definitions and philosophies, but they share the ability not to be limited by incorrect or false assumptions. Both look for unbiased data to analyze, as well as identifying known and unknown factors that influence the process (as measured in metrics like length of stay or readmission rates).

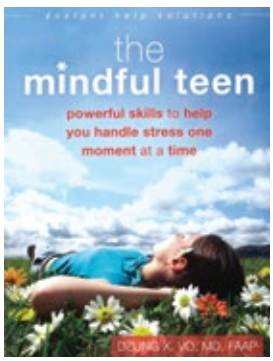
By combining real-time data with a number of different continuous improvement tools, a behavioral health provider is able to make real-time changes to treatment to improve the current service for an individual or a segment group. Thus, the use of these new continuous improvement methods can improve the effectiveness and efficiency of treatment services for both the patient and provider.

Jason Raines is Director of Systems Improvement and Business Analytics at KidsPeace. He is currently a doctorial student with his proposed dissertation on the use of continuous improvement methods in behavioral health care. Jason is also a Six Sigma Black Belt and university certified Lean Sensei.

Healing MAGAZINE
High Fives

The Mindful Teen

By Dzung X. Vo



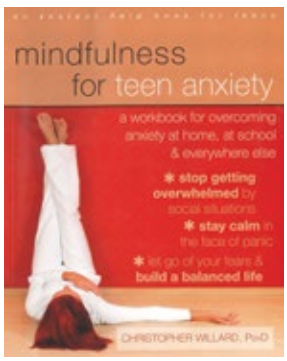
Conventional wisdom says teenagers as a whole lack the patience, attention span and maturity to pursue mindfulness as a response to stress. But based on his experience as a pediatrician specializing in adolescent medicine, Dr. Dzung X. Vo says the opposite is true. And in his book *The Mindful Teen* he distills the concepts of mindfulness and meditation into an accessible, common-sense presentation of the background and benefits of such practices to teens in their daily lives.

Vo is on the staff of British Columbia Children's Hospital and teaches at the University of British Columbia in Vancouver. He takes the reader on a step-by-step introduction to mindful practices, while linking the individual concepts to real-world concerns and situation through first-person discussions from teens who went through his course on the subject, Mindful Awareness and Resilience Skills for Adolescents (MARS-A). Their stories of using the concepts in their own lives and interactions with others give the somewhat abstract concepts more relevance to readers' challenges. Following the presentation of core mindfulness techniques, Vo shows their utility in specific situations and relationships, and offers a guide to teens on how to apply the general concepts into an action plan that addresses their unique life journey.

Vo frequently notes that teens should use the techniques that work best for them, rather than following the plan he presents without exception. That emphasis on flexibility, combined with his easily understood approach to communicating the concepts, gives The Mindful Teen an accessible and welcoming tone for the target audience. *(Published 2015; also references downloadable audio recordings for guided meditations at www.newharbinger.com/30802)*

Mindfulness For Teen Anxiety

By Christopher Willard



The role of mindfulness specifically to address teen anxiety is the subject of Christopher Willard's workbook-style entry in New Harbinger Publications' "Instant Help Books for Teens" series. *Mindfulness for Teen Anxiety* takes the reader through an overview of anxiety and its effects on the body and mind, and then introduces basic mindfulness concepts and their ability to help teenagers cope with anxiety. The remainder of the book provides mindfulness exercises to use in specific situations – at home, school, in your social life and others.

Willard seeks to engage the reader throughout by presenting exercises that call on them to think deeply about their response to anxiety and to try out simple mindfulness techniques in order to understand the impact they can have. Willard sums up the central purpose of the work in his introduction, where he says the goal is to train your mind to work for you and not against you. The first section on anxiety may be especially good to share also with parents and caregivers who may not be familiar with the inner emotional world and common coping techniques of the modern teenager. *(Published 2014)*

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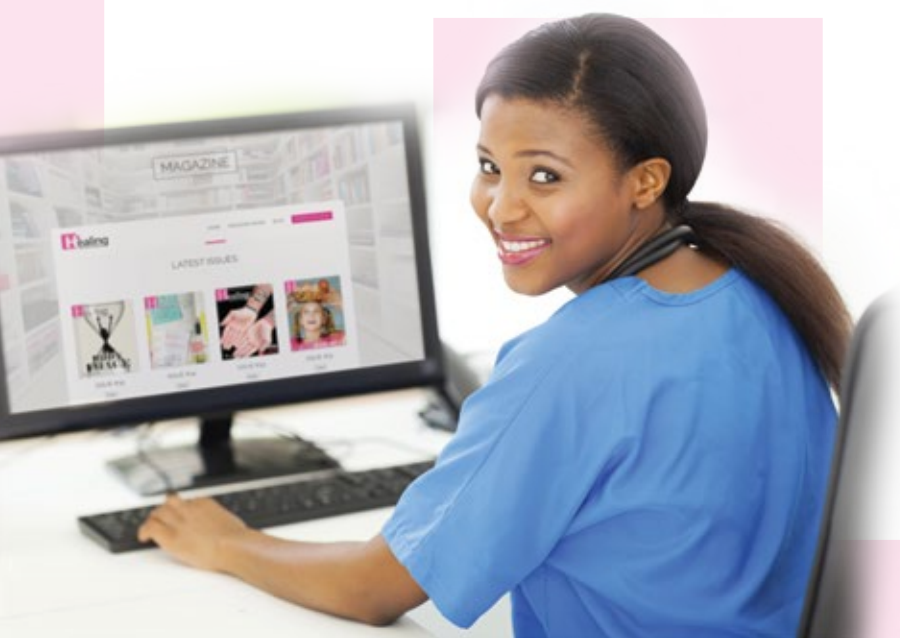

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